7. Additionally, each HMO will provide the following information within five days after notice of enrollment:

   a. Benefits offered, the amount, duration, and scope of benefits and services available.

   b. Procedures for obtaining services.

   c. Names and locations of current network providers including those providers not accepting new patients.

   d. Any restrictions on freedom of choice.

   e. The extent to which there are any restrictions concerning out of network providers.

   f. Policies for specialty care and services not furnished by the primary care providers.

   g. Grievance and complaint process.

N. Quality of Health Care and Services, Including Access

To assure quality of health care services in this document, the State shall perform the actions listed in this section.

1. The State shall require, by contract, all HMOs and providers to meet certain State-specified standards for Internal Quality Improvement Programs (QIP's).

2. On a periodic or continuous basis, the State shall monitor the adherence to these standards by all HMOs, through the following mechanisms:

   a. Review of the written QIP for each HMO to monitor adherence to the State's QIP standards. Such review shall take place prior to the State's execution of the contract with the HMO and each contract renewal period thereafter. The contract renewal period is every two years.

   b. Periodic review of numerical data and/or narrative reports describing clinical and related information on health services and outcomes of health care for the Medicaid enrolled population. This data will be submitted to the State on at least a semi-annual basis.

   c. Monitoring of the implementation of the QIP shall be conducted to assure compliance with the State's QIP standards. This monitoring shall be conducted on-site at both the HMO administrative offices and the care delivery sites. At least two such monitoring visits shall occur per year.

d. Monitoring through the use of State Medicaid agency personnel and contracted staff.

3. The State will arrange for an independent, external review of the quality of services delivered under each HMO's contract with the State. The review will be conducted for each HMO contractor on an annual basis. The entity which will provide the annual external quality reviews shall not be a part of the State government, HMOs, or an association of any HMOs.

4. Recipient access to care will be monitored as part of each HMO's internal QIP and through the annual external quality review for HMOs. The periodic medical audits described in par. 1., the State monitoring activities described in par. 2, and the external quality review described in par. 2, shall all derive the following information:

   a. Periodic comparisons of the number and types of Medicaid services before and after the institution of the AFDC-Related/Healthy Start HMO Program.

   b. Recipient satisfaction surveys managed by State staff.

   c. Periodic recipient surveys which contain questions concerning recipient access to services which the HMOs will conduct.

   d. Measurement of waiting periods to obtain health care services; including standards for waiting time and monitor performance against these standards.

   e. Measurements of referral rates to specialists.

   f. Assessment of recipient knowledge about how to obtain health care services.

   g. A requirement that HMOs submit utilization and encounter data.

O. Access to Care

In addition to the above processes, the AFDC-Related/Healthy Start HMO Program is not likely to substantially impair access because of the following:

1. Recipients may choose any of the participating HMOs in the service areas. The State will make available an HMO-certified service area map that is updated each contracting period. In addition, as per 42 CFR 434.29, within an HMO each Medicaid enrollee has a choice of health professional to the extent possible and feasible.

2. The same range and amount of services that are available under the Medicaid fee-for-service program are available for enrollees covered under the AFDC-Related/Healthy Start HMO Program.

3. State-specified access standards for distances and travel miles to obtain services for recipients under the AFDC-Related/Healthy Start HMO Program have been established. Specifically, the HMO must have a primary care provider within 20 miles, and a dental provider, mental health provider, and substance abuse provider within a 35-mile distance from any enrollee residing in the HMO service delivery area.

4. The number of providers to participate under the AFDC-Related/Healthy Start HMO Program is expected to increase.

5. Primary care and health education are provided to enrollees by a chosen or assigned HMO. This fosters continuity of care and improved provider/patient relationships.

6. Pre-authorization is precluded for emergency/post stabilization and family planning services under the AFDC-Related/Healthy Start HMO Program.

7. Recipients have the right to change plans if good cause is shown.

8. HMOs are required to provide or arrange for coverage 24 hours a day/7 days a week.

9. The same state hearing appeals system in effect under the Medicaid fee-for-service program will be in effect under the AFDC-Related/Healthy Start HMO Program. Recipients have available a formal appeals process under 42 CFR Part 431, Subpart E.

10. The state assures that state-determined access standards are maintained by use of a Geographic Mapping program.